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Health Insurance in Denmark

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HEALTH INSURANCE IN DENMARK

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FOREWORD

This memorandum is a revision of the previous bulletin on Denmark published in October, 1950, which was the second of the Research Division's Social Security Series designed to provide information on health insurance schemes in other countries. Other studies in the series include health insurance programs in New Zealand, Sweden, Norway, the Netherlands and Great Britain.

Denmark's long experience in health insurance is particularly useful in giving some perspective to a study of the subject. Of about 40 countries which have various types of health insurance, Denmark is one of the pioneers, having entered the field in the late 19th century.

The Danish program interlocks a health insurance system with highly developed public health and hospital care programs. To the extent that public health services and hospital care have been strengthened and expanded, the area for the development of health insurance benefits has been in some degree narrowed. While increased public control and financial support have accompanied the growth of the numerous voluntary health insurance organizations, a large measure of autonomy has remained with these local organizations.

The administrative integration of health insurance services and income maintenance payments during illness is an important feature of the Danish program. In turn, this dual program is closely associated with other social security measures, such as invalidity and old age pensions.

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This bulletin has been prepared in close co-operation with the Directorate of Health Insurance Studies. The comments and suggestions of the officials in that Directorate have been particularly helpful.

We wish to acknowledge and express appreciation for the generous assistance provided by Danish officials. Through their co-operation we received official documents and reports as well as a clarification of many aspects of the program set out in the first edition of this bulletin.

The 1950 edition of the bulletin was prepared by Alex Morris, while the work on this revised edition was carried out by Douglas G. Hartle under the supervision of Lloyd Francis, supervisor of the Social Security Section, and John Sparks who is in charge of public medical and hospital care studies in that section.

Joseph W. Willard,
Director, Research Division.

February, 1952.

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I INTRODUCTION

Health insurance in Denmark, as in several other European countries, began during the latter part of the 19th century (1892) with the development of voluntary state-regulated and subsidized mutual aid socieities designed to assist members in the event of unemployment, ill health, death or other personal misfortune. The two-fold problem of illness, namely the service required to restore health and the concurrent need for income maintenance, was met through the provision of a wide range of health services as well as cash sickness allowances.

The right to insurance benefits is obtained through membership in either state-approved and subsidized "Sick Funds" or state-approved and nonsubsidized "Sick Benefit Societies". Membership on a voluntary basis is available from 14 years of age, although all Danish citizens between 21 and 60 years of age must hold membership in one of these organization. While a citizen may not wish to be actively insured for health benefits, he must take out "passive" membership. This membership does not provide benefits but does allow "passive" members, together with their dependent children, to transfer voluntarily to "active" membership and receive full benefit rights, following a six month's waiting period, without age[1] or health qualifications. A person aged 60 years or over has the right to withdraw from membership, but withdrawal means the forfeiture, ipso facto, of the right to invalidity

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(1) Except in the case of transfer to active membership in a Sick Benefit Society (non-subsidized), where an age limit of 40 years is in force.

insurance and old age pensions which are dependent upon continued health insurance membership.

The national government requires that the health benefits provided by Sick Funds and Sick Benefit Societies include general practitioner care, diagnostic services, hospital services, maternity services, and the provision of three-fourth of the cost of certain "vital" and "specially important" medicines. Complete or partial coverage can be provided, on the decision of each Fund or Society, for private specialist services, convalescent care in special homes, dental services, home nursing services, three-quarters of the cost of certain drugs prescribed by the physician in cases of protracted and serious illness, spectacles, an other supplementary services. Cash sickness allowances are paid during illness, (after a waiting period of four days) and may extend for a period of up to 26 weeks within 12 consecutive months, and for up to 60 weeks within three consecutive calendar years. The value of the cash benefit is dependent upon the premium the member has paid, but may not exceed four-fifths of the recipient's regular wage.

The Danish program is financed in the main from membership contributions, which are paid, by "passive" members, at a flat nominal rate and by "active members" at a higher rate which varies with the amount of cash sickness insurance the individual has decided to carry, and the scope of the voluntary benefits which the Fund or Society provides.

State-subsidized Sick Funds receive almost a quarter of their revenues from direct state or local subsidies. In addition, the Danish public health system, particularly the Danish hospital program, provides both free or low-cost public health care services.

The Danish scheme, while under national supervision and control, is administered locally by nearly 1,600 Funds and Societies which are largely self-governing. The effectiveness of this decentralization and local autonomy is aided by special consultative and appeal authorities.

The health insurance program should be considered against the background of Denmark's social and economic setting. The Kingdom of Denmark which occupies part of the Jutland Peninsula and a group of islands dividing the North and Baltic Seas, has an area of 16,575 square miles, about three-quarters of the area of Nova Scotia and supports a population of 4.2 million people. The density of population, 253 persons per square mile, is much larger than the other Scandinavian countries, although Denmark is the smallest in area, and is concentrated in the islands and the eastern part of Jutland. About one half of the population live in urban areas, 20 per cent in the capital, Copenhagen.

Denmark has a smaller percentage of its population under 20 years of age than Canada, and a larger percentage over 65 years of age. Thirty-three per cent of the Danish populace is under 20 years as compared with 37.3 per cent in Canada, while 8.7 per cent are over 65 years of age compared with 7.7 per cent in Canada.

The birthrate, which at the beginning of the century was about 30 per thousand, declined until it reached 17.3 per thousand in 1933. The rate then increased until 1945, but declined again to 18.9 in 1949. The death rate has remained relatively constant, from 10 to 11 deaths per thousand during the same period.

Industry and commerce employ half the working people of Denmark, and another quarter are engaged in agriculture, the only important natural resource which the country possesses. The land, which is nearly all productive, is farmed intensively, with over 75 per cent of the area under cultivation.

The struggle for responsible government, which was a manifestation of the liberal spirit, swept Denmark, as it did many other European nations, in the latter half of the nineteenth century. This movement engendered social legislation which has given Denmark one of the most advanced social welfare programs in the modern world.

II HEALTH INSURANCE AND OTHER SOCIAL SECURITY PROGRAMS

One of the important features of Danish health insurance development is the extent to which the system has been integrated with other income security and welfare measures. This integration began as early as 1921, when the voluntary health insurance scheme which then existed was co-ordinated with a national compulsory invalidity insurance program. It was not until the passage of the Social Reform Acts in 1933, that any large scale systematic attempt was made to co-ordinate all of the existing social security schemes. This reform legislation, which has formed the structure for all later social legislation in Denmark, consisted of four acts: the National Insurance Act, governing health and invalidity insurance and old age pensions; the Workmen's Compensation Act; the Labour Exchanges and Unemployment Insurance Act; and the Public Assistance Act. The integration of the health insurance scheme with these programs, as the brief outline in the following sections will indicate, emphasizes the pivotal position of the health insurance system in the Danish pattern of social security.

INVALIDITY INSURANCE

The national invalidity insurance program, first implemented in 1921, was closely integrated with both the health insurance and old age pension programs through the National Insurance Act of 1933.

The invalidity program, which is financed by compulsory contributions from both the insured and employers, as well as by subsidies from the national and local governments, has, since its inception, covered only persons enrolled under national health insurance. Combined with the provision of cash benefits, the law requires the submission of beneficiaries to preventive and curative treatment, provided by the health insurance organizations with the costs to be refunded to these organizations from invalidity insurance Fund revenues. The collection machinery of the health insurance scheme is utilized to collect personal invalidity insurance contributions.

OLD AGE PENSIONS

Non-contributory old age pensions, subject to a means test and financed by general revenues, were first established in 1891. Since the passage of the National Insurance Act of 1933, membership in the health insurance program has been one of the qualifying conditions for receipt of an old age pension.

WORKMEN'S COMPENSATION

The Workmen's Compensation program is also closely related to the health insurance stystem, in that it presupposes that all workers are covered for benefits under health insurance. Neither ordinary health services(1), nor cash

(1) The legislation makes provision for certain specified specialist medical services and appliances.

maintenance is provided under Workmen's Compensation for the first thirteen weeks following an accident, as it is assumed that these areas of need are met for the worker through health insurance membership.

All types of work accidents and most occupational diseases are covered by the scheme which is mainly financed by employers (86 per cent in 1942-43), and state subsidies.

OTHER SOCIAL PROGRAMS

Unemployment insurance, family allowances, and public assistance complete the social security system, but only the latter program is related to health insurance.

The current public assistance program, for which financial responsibility rests solely with local authorities, is designed to cover cases of need that fall outside the scope of the various social insurance and welfare schemes. It is specifically related to health insurance in the provision of what is termed "special assistance". If special need is proven, financial aid may be granted to chronic invalids and mental cases, or to those who fall in arrears with their health insurance contributions or exhaust their quota of sick benefits under the health insurance scheme.

III PUBLIC HEALTH AND HOSPITAL SERVICES

The public health and public hospital systems play an important part in the over-all functioning of the Danish health insurance scheme. The public health program, in addition to offering the more traditional preventative and curative services for contagious diseases, tuberculosis, cancer, mental illness, and so on, also includes national programs providing maternal aid, child welfare and visiting nursing services that complement the services provided under the health insurance program. Some notable provisions under these three latter schemes are: free preventive health examinations for all expectant mothers, free milk for all needy women during and immediately following pregnancy, public health nursing services to all homes with children under one year, free medical examinations for all pre-school and school children, and a national system of well-baby and child welfare clinics.

Probably the most outstanding feature of the Danish public hospital system is the extent to which it makes low-cost hospital care, including all necessary medical, nursing and laboratory services, available to the entire population. In 1949, ward-care charges in general hospitals ranged from

a maximum of 4 crowns[1] per day to as low as 0.6 crowns per day, depending on the district.[2] By means of local subsidy, even these low charges are reduced by one-half for Sick Fund members. Through these subsidies and discounts, complete medical services and treatment in hospitals are available to all at nominal cost.

The hospital system is currently comprised of over 300 curative institutions with over 44,700 beds, or almost 10.6 beds per 1000 population (1949). With the exception of four large general hospitals operated by the national government and a few private hospitals run by religious orders, the general hospitals traditionally are owned and operated by county and municipal authorities, subject to some supervision by the national government. The general hospitals have

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(1) The Danish crown could be exchanged for 20.83, 15.92, 16.03 and 15.28 Canadian cents on September 1st and 20th, 1949, September 1950 and 1951 respectively. It should not be inferred that the value of Danish goods and services can be discovered by a simple translation of Danish crowns into Canadian dollars at the going exchange rate. The differences between the per capita incomes of the two nations, the variations and fluctuations in price levels, and the fact that the goods and services are not necessarily equivalent in type or quantity, make this procedure yield only approximate results.

(2) The wide discrepancy between patient charges and operating costs per patient day is illustrated by the fact that in 1950 the operating cost averaged 20-30 crowns.

developed in a pattern which provides each county with at least one or two large central hospitals, equipped with medical and surgical departments and in most cases with other special departments, and in addition, several smaller municipal hospitals. In 1950 this system included two medical centres, 26 Central Hospitals, and 107 District Hospitals, as well as 17 private hospitals mostly owned by Catholic orders.

The provision of special disease hospitals for mental illness, epilepsy, invalidity, blindness, and deafness, etc., is largely the responsibility of the national government.

A recent summary of hospital capacity in Denmark is set out in Appendix I.

IV THE HEALTH INSURANCE PROGRAM

The health insurance program in Denmark operates through two distinct types of voluntary associations: state-approved, subsidized organizations called "Sick Funds" and state-approved, non-subsidized organizations called "Sick Benefit Societies". The Sick Funds constitute the real core of the system, covering about 90 per cent of the insured population. Since both organizations provide approximately the same range of benefits, the following discussion deals mainly with the operation of Sick Funds.

A. COVERAGE

Persons with limited incomes are covered under the health insurance scheme through contributory membership in state-approved and subsidized Sick Funds (numbering 1,586 in 1951). Persons with considerable "means", on the other hand, are covered through contributory membership in the state-approved non-subsidized Sick Benefit Societies (18 in number). The income limit for membership in Sick Funds is adjusted annually to correspond with the earnings of a skilled worker, and also in accordance with variations in the cost of living by areas. In assessing income for this purpose, not only current income but also capital holdings are taken into account. The upper income limits for Sick Fund active membership in 1950 were: in Copenhagen, 9,300 crowns; in provincial towns, 7,700 crowns; and in rural areas 6,700

crowns[1]. Active members of Sick Funds have a duty to notify the Fund when their income passes the upper limit, and are then transferred to passive membership in a Fund or to active membership in a Sick Benefit Society[2].

The great majority of Danish citizens are enrolled in subsidized Sick Funds. Membership in these Funds totalled more than 2.6 million persons in 1949, as compared to about a third of a million enrolled in Sick Benefit Societies during the same year, as shown in Table I.

Membership in Sick Funds or Sick Benefit Societies is usually determined on a geographical area basis, but some Sick Funds are restricted to a single trade or occupational group. In the latter case, provision is made for members retaining their membership in the original Fund on changing occupation.

TYPES OF MEMBERSHIP

There are two kinds of membership offered by both the Sick Funds and the Sick Benefit Societies. "Active membership" may be applied for by any Danish citizen between the ages of 14 and 40 years who meets what appears to be very lenient health qualifications. Membership of this type entitles the insured and any dependent children to full benefit rights in the event of illness. Wives of insured

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(1) See p. 10.

(2) A periodic income check is carried out by a local government committee set up by the commune. Decisions of the committee must be approved by the Directorate.

persons must take out separate insurance and, in the case of Sick Funds, certain orphans under 15 years may be admitted to active membership in their own right. "Passive membership", however, is compulsory for all citizens over 21 who are not already or do not want to become, active members. Passive membership does not entitle the individual to benefits but only to the right to admission to active membership in either type of insurance organization at any age and regardless of health condition. The main object of compulsory passive membership is to urge people fulfilling the conditions for active membership to join as such. In 1949 the total health insurance membership, including approximately three million enrolled members and an estimated 938,000 dependent children, represented about 92 per cent of the total population of Denmark in that year (4.23 million). As shown in Table I below, of the total enrolled members, nearly 2.7 million, or almost 90 per cent had obtained active membership. Membership data for the years 1939 to 1949 are given in Appendix II.

Table I - HEALTH INSURANCE MEMBERSHIP IN SICK FUNDS AND SICK BENEFIT SOCIETIES, BY TYPE OF MEMBERSHIP, 1949(1)

Type of Membership	Subsidized Sick Funds	Non-Subsidized Sick Benefit Societies	Total
Active	2,373,000	316,000	2,699,000
Passive	275,000	4,000	279,000
Total(1)	2,648,000	320,000	2,968,000

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Membership figures do not include children, but dependent children of active members of both types of insurance organizations are insured for the same health benefits as their parents at no additional cost. Danish authorities estimate that 823,000 children are eligible for health benefits by virtue of their parents' membership in approved Funds. Approximately 115,000 children are eligible for benefits in non-subsidized Sick Benefit Societies.

B. ELIGIBILITY

Generally speaking, the health qualifications for both active and passive membership appear to be lenient, but the qualifications of Sick Benefit Societies are more restrictive than are those of Sick Funds. For example, when applying for membership in Sick Funds, persons who are chronically ill or disabled are considered individually, by the national supervisory authority, and such persons may be allowed to join as "impaired risks" for full health services

but limited cash benefits[1]. Sick Benefit Societies, on the other hand, do not accept persons suffering from either temporary or chronic illnesses.

A qualifying period of six weeks is required of all active members before they are eligible to full benefit rights, except for conditions resulting from an accident, or for maternity benefits which require a ten-month qualifying period. No qualifying period is required in the case of dependent children.

An active member of a Sick Fund whose income increases beyond the limit specified for membership must transfer, with full benefit rights and without any waiting period, either to the appropriate Sick Benefit Society or to passive membership in his Sick Fund. In the same way, Sick Benefit Society members who experience a decrease in income must transfer to a Sick Fund. Financial position, based upon income and capital holdings, is an important factor in determining eligibility, but this criterion is flexible, since a person's whole financial standing is taken into account, and no rigid standard attempted. Furthermore, active members upon changing residence, must transfer membership to the appropriate insurance organization in the new area with fully accrued benefits.

Passive members may transfer to active membership at any time regardless of health condition or age but they are not eligible for benefits until six months after the transfer has been made.

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(1) Persons in the "impaired risk" category may not insure themselves for cash benefits beyond a maximum of 3 crowns per day.

C. BENEFITS

GENERAL PROVISIONS

(1) Scope

Benefits provided by Sick Funds are classified into two groups: mandatory benefits, with their scope and nature specified by the Act; and permissive benefits. Included in the former group are general practitioner services, hospital services, maternity services, the partial provision of certain drugs, daily cash allowances, and funeral aid.(1)

The permissive benefits which Funds may provide are partially delineated by the Act, and partially in a set of "model rules", prepared by the Directorate, upon which the rules of all the Funds are based. The Funds may only modify the less important provisions of these "model rules", and while they are free to decide which permissive benefits they will provide, the nature and scope of the benefits must largely conform to the "model rules". Generally, the permissive benefits include, on either a full or partial basis, such services as specialist treatment, dental services, convalescent home care, additional types of drugs, home nursing services, massage treatment, bandages and surgical appliances, and spectacles. In the discussion which follows,

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(1) Approximately the same range of benefits is provided by both Sick Funds and Sick Benefit Societies; details given here apply specifically to Sick Funds.

benefits of the permissive type will be specially noted as such.

(2) Duration

The regulation of the duration of health service benefits is such that, if a member receives any type of treatment for as many as 420 days in three consecutive years, he is transferred to passive membership for at least 12 months; at the end of this time, reinstatement to active membership is permitted if medical certification of good health is provided. With regard to this limitation, a non-official source(1) reports that it is rather complicated to administer and is not applied rigidly. For example, in the case of members who are hospitalized and are concurrently in receipt of other services, only one of the services is counted against the 420 days. Similarly, if an insured person is receiving drug benefit, and is under the care of a doctor, only one of these benefits is counted in calculating the "days of service".

HEALTH BENEFITS

(1) Medical Benefits

(a) General Practitioner Services

Scope - Services cover all office and home consultations and necessary treatment, plus bandages and medicants used in treatment, and travelling expenses in rural areas.

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(1) Peebles, Allon, Health Insurance in Europe, Report of Chairman of British Columbia Health Insurance Commission, 1939, p. 152.

Method of Computing Duration - The method of computing the 420 days' treatment for which a member is eligible over a period of three consecutive years is as follows: if medical attendances are on consecutive days, or if less than one week intervenes between attendances, the days are counted as continuous; however, if more than one week intervenes between attendances, only the exact number of days of treatment are counted against the 420 days.

Procedure for Obtaining Services - About three-fourths of the total number of actively-insured members of Sick Funds obtain general practitioner services from physicians receiving their remuneration based on a flat annual payment per capita (the capitation scheme); under this arrangement, patients are allowed free choice of any doctor on a yearly basis. The remainder of the actively-insured receive such services from fee-for-service practitioners, whereby they are free to choose from among any of the practitioners operating within a specified radius (believed to be a radius of six miles from the location of the Sick Fund to which they belong). Some Funds on a fee-for-service basis may require that the members retain the same doctor for a year, but in others there is no stipulation whatever concerning the retention of a particular doctor, regardless of his method of remuneration.

(b) Diagnostic Services

Practically all x-ray and laboratory-diagnostic services in Denmark are provided by the hospitals,(1) to both in-patients or out-patients. Members of the Funds receive these services without charge, for the Funds pay the flat-rate, inclusive, hospital charges(2) for their members, if they are in-patients, or the scheduled fees for out-patient services.

(c) Specialist Services

In Hospital (mandatory) - All specialist services in hospitals are provided as a part of hospital treatment, and there is no benefit for this category of service as such. Out-patient specialist care(3) is provided in hospitals at a fixed schedule of fees, which the Funds pay in full for their active members.

Outside of Hospital (permissive) - All Funds make some provision for specialist treatment for their non-hospitalized members. The scope of the services available varies considerably. The widest range of specialist services (which nearly always includes an eye, ear, nose and throat specialist) is provided by the Sick Funds in Copenhagen.

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(1) Some diagnostic work is also carried out by the state-operated "Serum Institute".

(2) See "Hospital Benefits", p. 22.

(3) The out-patient services which hospitals must provide are specified in the hospital's regulations together with the rates which they may charge for these services.

A few federations of Sick Funds (i.e. Central Unions) have entered into agreements with other specialists, such as dermatologists.

(2) Hospital Benefits

The hospital services should be viewed in the light of the previously mentioned low-cost hospitalization available through the public hospital system. The hospital service benefits simply eliminate what, to begin with, are comparatively negligible patient charges.

All Sick Funds in Denmark make provision for complete treatment for remedial purposes in public general, tuberculosis and mental hospitals up to a maximum period of 420 days within three consecutive years. Some Funds also undertake to provide treatment at other remedial institutions, such as convalescent homes, but none of the Funds provide benefits for maintenance in institutions for the mentally defective, the blind or the deaf and dumb.

(a) In General Hospitals

The services in public general hospitals include complete in-patient treatment, i.e., diagnostic and x-ray services, general and specialist medical and surgical treatment, nursing services, bandages and drugs used in treatment, and also transportation to and from hospital for patients in rural areas. In addition, all Funds pay for their members' treatment in out-patient departments and for follow-up care after hospital discharge. Services provided in private general hospitals correspond to those provided in public institutions.

(b) In Special Hospitals and Approved Institutions

Sick Funds provide full benefits for the maintenance and treatment of psychotic patients (but not mental defectives) in state, county or municipal mental hospitals, and for patients in tuberculosis hospitals and sanatoria, and institutions for the treatment of cancer.

About 80 per cent of the Sick Funds provide care in convalescent homes (a permissive benefit), but only if it constitutes the final stage of treatment. It should be noted in this connection that seven of the 23 state-approved convalescent homes in Denmark are owned and operated by Sick Funds or federations of Sick Funds.

(3) Maternity Benefits(1)

Full maternity services, covering midwife, medical and hospital services, are available to all women who have had active membership in a Sick Fund for at least ten months.

Midwife services consist of attendance by a trained midwife during confinement. Physician services are provided in cases where the attending midwife judges it to be necessary. Finally, the hospital maternity services provide full hospital or maternity-home services if the attending midwife or physician anticipate a difficult birth.

(4) Pharmaceutical Benefits

Important or "vital medicines" are partially provided under the benefits on the recommendation of a medical practitioner. Such benefits include insulin for diabetes,

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(1) For cash maternity allowances, see Cash Benefits, p. 28.

liver preparations for pernicious anaemia cases, and luminal for epileptics, i.e., medicines which are usually required over a long period and, therefore, are costly. Provisions exist for adding other preparations to the "vital medicine" category.

In addition to providing three-fourths of the cost of "vital medicines", the Funds, as a mandatory benefit must pay, under a 1951 amendment to the Act, three-fourths of the cost of a series of drugs grouped together as "specially important",(1) and may pay three-fourths of the cost of certain prescribed drugs(2) in cases of serious and protracted illness.

(5) Other Benefits

As well as specialist and convalescent care and "other medicines", a variety of additional benefits are provided on a permissive basis, to supplement the basic compulsory benefits. Most Sick Funds provide partial dental benefits covering extractions and preventive treatments, and three of the Funds operate their own dental clinics for this purpose. About one-half of the Sick Funds provide full benefits covering home nursing services in addition to the nursing services provided under the hospital benefits. These services may consist of either brief visits or of full day-care, depending on the circumstances.

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(1) Formerly one-half the cost was met by the Funds, as a permissive benefit.

(2) A new drug benefit. Includes certain hypnotics, sedatives, analgetics, antipyretics, antirheumatics, antacids, and remedies for local application in skin diseases and infections of the mucous membranes.

About two-thirds of the Sick Funds provide benefits covering massage treatment while about one-half provide benefits covering medicinal bath treatment; both these services may be provided on a full or partial basis. Some of the Funds own and operate special massage clinics that provide treatment under specialist supervision, e.g., Funds in Copenhagen operate three clinics of this type while 24 other Funds in out-lying areas also maintain similar clinics. Finally, some Funds provide partial benefits covering bandages, surgical appliances, and spectacles.

CASH BENEFITS

(1) Cash Benefits for Income Maintenance

Cash benefits for income maintenance during an illness involving loss of working capacity are payable to active members for a maximum period of 26 weeks within 12 months and a maximum of 60 weeks, in the course of three consecutive years. The amounts, which vary from 4.4 crowns to 6 crowns per day (1949) but which must not exceed four-fifths of the person's average daily wage, are paid after a four-day waiting period upon certification of incapacitation by the patient's own physician. All active male members over 18 years of age must insure themselves for this benefit; males under 18 and women are under no obligation to do so.

As will be noted in the financial discussions on the Danish program, much greater emphasis has been placed on the treatment of sickness, than on the provision of cash

sickness benefits. According to a responsible Danish official, the certification of incapacity very rarely involves abuse, probably because of the fact that most of the local Sick Funds are small with their members well acquainted, and also that the cash benefits are not sufficiently large to encourage abuse.

(a) Utilization

In 1949 about 2,373,000 active members of Sick Funds were eligible for cash sickness allowances. Ninety-five per cent of these persons, distributed about equally as between men and women were "ordinary members", that is those who met the upper age limit (40 years) and health qualifications at enrollment, and subsequently had not become chronically ill. The remainder included three per cent of the total membership who were admitted to the Funds in 1933, when the present program was inaugurated and were over 40 years of age at that time. These so-called "older" members together with an additional two per cent, classified as persons suffering from chronic diseases, complete the total eligible for cash benefits.

As shown in Table II (see page 29) the "older" members and those suffering from chronic diseases in 1949, had considerably higher utilization rates than the ordinary members. In fact certification of illness of those with chronic diseases, (the "impaired risks"), was about double the rate of certification of ordinary members and the former

members, as a group, were incapacitated for about three times as long as ordinary members and almost twice as long as "older" persons (at least 55 years of age or more in 1949). In examining the rates of certification per hundred insured members, and the number of benefit days per member certified sick, it should be noted that while more chronic members were declared eligible for benefits than members in the other two groups, the fewer "older" members who were certified ill received the benefit for nearly the same period of time as the chronically ill. To illustrate, while the ordinary members certified sick received cash benefits for an average of 31.5 days, the "older" and chronic disease class received such payments for about 43.8 and 45.7 days respectively; in short, a large proportion of the so-called "older" members were suffering from chronic diseases requiring a longer duration of incapacitation.

Considering the utilization experience of men and women, it appears that those women classed as ordinary members not only had a higher rate of certification, as a group, but also the average duration of illness for women certified ill exceeded the male rate by about 2½ days. The disparity between the male and female rates for those chronically ill is particularly noticeable. In the so-called "older" group, however, considerably fewer women than men were certified sick and their duration of illness was on the average a full day shorter.

Since the Danish cash benefit program only pays such benefits after a four-day waiting period, it can be inferred that the average period of incapacitation per member insured was 4.6 plus an additional four-days' waiting period or a total of 8.6 days. The average period for those members certified as incapacitated then rises from 32.4 to 36.4 days.

(2) Cash Maternity Allowances

If insured for cash allowances during ordinary illnesses, women are entitled to daily cash maternity allowances, in the same amount, (4-6 crowns per day) for fourteen days during confinement. For working women, this allowance is available for a period of 8 weeks before confinement and for the third to the sixth week after confinement.

Table II - PERCENTAGE DISTRIBUTION OF MEMBERSHIP, NUMBER OF PERSONS CERTIFIED SICK PER 100 MEMBERS, NUMBER OF BENEFIT DAYS PER 100 MEMBERS, AND AVERAGE NUMBER OF BENEFIT DAYS PER PERSON CERTIFIED SICK, BY TYPE AND SEX OF MEMBER, SICK FUNDS, 1949

	Percentage Distribution of Membership			Number of Persons Certified Sick Per 100 Members			Number of Benefit Days Per 100 Members			Average Number of Benefit Days Per Person Certified Sick(1)		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
Ordinary Active Members	45.6	49.3	94.9	12.5	15.0	13.8	379	492	437	30.0	32.6	31.5
Members Over 40 Admitted 1933(2)	1.3	1.6	2.9	17.0	14.2	15.5	739	625	678	43.5	44.1	43.8
Members Chronic Diseases	0.8	1.1	1.9	22.9	29.3	26.6	970	1396	1215	42.3	47.6	45.7
All Members	47.9	52.0	100.0	12.92	15.36	14.19	400	515	460	30.9	33.57	32.42

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) The average number of days of incapacitation will be actually four days greater than the number of benefit days shown since a four day waiting period is imposed.

(2) These members were over 40 years of age in 1933 when the program was initiated, but were admitted to membership at that time under special provisions contained in Section 74, part 2 of the Act.

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V FINANCING THE HEALTH INSURANCE PROGRAM

The financing of both the subsidized Sick Funds and the non-subsidized Sick Benefit Societies is discussed below for the year 1949. The expenditures of these two types of organization in that year were 161.9 million crowns and 17.5 million crowns, respectively, and represented, in total, about one per cent of national income(1).

Details of the revenues and expenditures of Sick Funds for the years 1939 to 1949 are given in Appendices III and IV. Expenditures of Sick Benefit Societies for the same years are given in Appendix V.

A. SICK FUNDS

REVENUES

Direct contributions from members are the chief source of revenue of the Danish Sick Funds as shown in Table III; state subsidies comprise only about 20 per cent of revenue and subsidies from local authorities about 2.5 per cent.

(1) Members' Contributions

The total revenue from the contribution of both active and passive members was approximately 116 million crowns in 1949, or about 70 per cent of the total revenue from all sources for that year.

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(1) It should be noted that these expenditures do not cover all Danish health insurance costs; factors such as the reduced hospital charges for Sick Fund members and partial benefit rates would have to be considered in estimating total costs.

(a) Active Members' Contributions

The contributions from active members, which amount to about 99 per cent of total membership contributions, vary with the amount of cash maintenance benefits for which the person is insured. Furthermore, since expenditures for both health services and cash benefits vary between Funds, these two factors combine to cause considerable variation in contribution rates of members. The average monthly contribution paid by active members of Sick Funds is approximately four crowns.

Table III - AMOUNT AND PERCENTAGE DISTRIBUTION OF SICK FUND REVENUES, BY SOURCE, 1949

Source of Revenue	Amount	Per Cent of Total
	(ooo crowns)	
Membership contributions:		
Active	114,960	70.0
Passive	709	0.4
State subsidy	34,056	20.7
Commune subsidy	3,960	2.4
Interest	1,803	1.1
Control charges(1)	2,057	1.3
Other	6,629	4.0
TOTAL	164,176	100.0

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Control charges refer to the extra fees required of patients who request service either on public holidays or during the night, or request service which is considered not immediately necessary. See p. 40.

(b) Passive Membership Contributions

The passive contribution rate, which is standard for all Funds, is set at the nominal sum of 2.4 crowns per year. Contributions from passive members are collected annually by the Sick Funds. Passive members over 40 years of age, whose payments fall in arrears for over five years, forfeit their right to become active members and also their rights to invalidity and old age pensions. However, local public assistance may be obtained by needy persons to meet insurance payments.

(2) Government Subsidies

(a) From the National Government

The other major source of revenue for Sick Funds is by way of subsidies from the national government. These subsidies, the amounts of which are regulated annually by legislation, totalled approximately 34 million crowns in 1949 and represented about 20 per cent of the total revenue for Sick Funds. It should be mentioned here that the direct national government subsidies to Sick Funds in 1948 represented only about 3.3 per cent of the total social expenditures by the government for that year.

The national government subsidies are apportioned to Sick Funds on the following basis:

(i) a subsidy of two crowns per year for every active Sick Fund member;

(ii) a subsidy representing one-fourth of the total annual expenditure of each Fund on health and cash benefits, (excluding expenditures on non-vital medicines, prostheses, spectacles, and so on).

(iii) a subsidy to each Fund equalling three-eighths of the amount that the average total expenditure on benefits to persons chronically disabled on admission to a Sick Fund exceeds the average total expenditure of the Fund for its other members.(1)

(iv) a subsidy representing one-quarter of the Fund's expenditure on maternity benefits.

It should be mentioned that state financial participation is limited to a proportion of expenditures on benefits only; the total cost of local administration is borne by the Funds.

(b) From Local Governments

Cash subsidies from local government authorities represent only a small fraction of the total revenue of Sick Funds; in 1949, the four million crowns obtained from this source represented only 2.4 per cent of total revenue.

In addition to the rather small direct monetary grants from the local governments, these authorities, however, grant the following important forms of assistance to the Funds:

(1) A Danish official has pointed out the inadequacy of this method of subsidization, and expressed the opinion that this provision may be abolished when the Act is amended. No alternative method was suggested.

(i) reduction of hospital charges for Fund members by at least half of the hospital's standard scale of charges;

(ii) transportation to doctors' offices and hospitals if Fund members live more than a certain specified distance from centres of treatment; medical practitioners likewise are given free transportation to members' homes (expenditure in 1945 was 9 million crowns);

(iii) aid towards paying membership contributions for those temporarily unable to maintain payment; in 1945, local authorities paid 1.6 million crowns for this purpose;

(iv) aid towards the cost of benefits for persons having chronic disabilities on admission to Funds; this particular form of assistance matches the national government's subsidy of three-eighths of extra expenditure;

(v) supplementary grants for special projects.

(3) Other Sources of Revenue

The remaining sources of revenue to Sick Funds, considered together, account for only a small proportion of the total revenue, just over 6 per cent in 1949, as shown in Table III.

EXPENDITURES

The total expenditure of Sick Funds, which rose from 76.3 million crowns in 1939 to 161.9 million crowns in 1949 in spite of only a slight increase in membership over the period (see Appendices II and IV), represented, in 1949, an average annual expenditure per active adult member of 68.25 crowns including administration. Health care benefits, which cost 117.1 million crowns in 1949, or 49.37 crowns per active adult member, have consistently been the largest expenditure and accounted for approximately 72 per cent of the total 1949 expenditure. This proportion of expenditure on health services compared with that on cash maintenance is in contrast to the Swedish health insurance program, where health care benefits account for only about 28 per cent of total benefit expenditures.

Cash maintenance benefits in Denmark accounted for only about 10.5 million crowns in 1949,(1) or only 6.5 per cent of the total expenditure, while administrative expenses totalling 19.1 million crowns represented almost 12 per cent of the total. The remainder of the expenditures for the year, amounting to 15.0 million crowns, or approximately 1.0 per cent of the total, covered miscellaneous items (including expenditures for funeral benefits).

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(1) It is estimated that if the provision of cash benefits did not involve any waiting period (4-7 days at present) the costs would increase about 20 per cent for men and 10 per cent for women.

(1) Division of Cost of Health Benefits

A summary of health benefit costs to Sick Funds for the year 1949 is given, by type of service, in Table IV following.

Table IV - AMOUNT AND PERCENTAGE DISTRIBUTION OF HEALTH EXPENDITURES AND EXPENDITURES PER ACTIVE ADULT MEMBER, BY TYPE OF HEALTH BENEFIT, SICK FUNDS, 1949

Type of Health Benefit	Health Expenditures		
	Amount	Per Cent of Total	Per Active Adult Member
	('000 crowns)		(crowns)
Medical practitioner	52,210	44.5	22.00
Hospital(1)	22,914	19.5	9.65
Pharmaceutical	18,312	15.6	7.71
Dental	8,258	7.0	3.47
Maternity (medical and midwife)(2)	7,035	6.0	2.96
Home nursing	2,562	2.2	1.07
Appliances, spectacles	2,924	2.5	1.23
Massage, baths	1,714	1.5	0.72
Convalescent home	1,228	1.0	0.51
Total	117,157,000	100.0	49.37

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Hospital expenditures include all in-patient physician and specialist services.

(2) Expenditures for maternity hospital services are included in the amount shown for hospital services expenditures.

(a) Medical Practitioner Costs

The cost of medical practitioner services has consistently represented the largest single item of expenditure on health benefits. The 52 million crowns expended by Sick Funds on medical practitioner services (general and specialist) in 1949 accounted, for 44.5 per cent of the total health service expenditures for that year, as shown in Table IV, and represented an average expenditure per active adult member of 22.0 crowns.

As was mentioned previously, general practitioners receive payment for their services from Sick Funds, under either a capitation or fee-for-service arrangement. About three-quarters of the total membership covered by the scheme obtain service from general practitioners receiving their remuneration under the former arrangement. Those specialists who are under agreement to provide consultation and treatment services outside of hospital, are generally remunerated on a capitation basis in urban areas and a fee-for-service basis in rural areas. If no agreement exists, the Fund may assume, under its rules, a certain percentage of the specialist's charges to the member, the maximum generally being one-half the bill, but not exceeding 50 crowns.

In the light of the fact that specialist care is available as part of the hospital services, it is interesting to note that the out-of-hospital medical services are very largely restricted to general practitioner care. As can be seen from Appendix IV the proportions of the total cost of

medical treatment spent for general practitioner and specialist services, were approximately 81 per cent and 19 per cent respectively.

Unpublished information supplied by the Minister of Social Affairs indicates that whereas the average annual expenditure of Sick Funds on general practitioner services was 17.9 crowns (1949), such services, when provided by physicians remunerated on a capitation basis cost an average of 16.72 crowns per member, as compared to 21.06 crowns under the more costly fee-for-service method of remuneration.

In considering the total remuneration of practitioners from the insurance scheme, it should be mentioned that with respect to general practitioners on capitation, the annual payment per ordinary member is increased by 50 per cent in cases considered as "impaired risks", that is those suffering from chronic disabilities. Such members pay the same contribution rate as ordinary members and the additional expenditures on their behalf are met by the Fund, with the assistance of special state and local grants.(1) Chronic members of Sick Benefit Societies, however, are required to pay contributions increased by 50 per cent in order to cover additional expenditures on their behalf.

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(1) See pages 34 and 35.

As well as the special payments mentioned above, physicians also receive additional remuneration from the Funds for service to chronic patients for night and holiday calls. In case of doctors on fee-for-service, the usual fee is increased by 75 per cent, while for those under capitation, a special payment, the usual fee-for-service fee increased by 60 per cent, is made.

Control Charges - Two types of deterrent or "control" charges, apparently to discourage unnecessary service demands by patients, are paid by the members themselves under both the fee-for-service and capitation systems of remuneration. In the latter case the charges - two crowns for an office visit and four crowns for a home visit - are levied only when a member uses the services of a doctor outside of office hours, particularly on public holidays and during the night. However, it seems that when such demands are considered as not being immediately necessary, the member must pay the whole cost of the services rendered. Patients receiving service from fee-for-service practitioners are required to pay a small sum for each visit to a doctor's office (half a crown), or for service rendered in the home (one crown). Some Funds using the fee-for-service method, also require that the above-mentioned capitation control charges be paid for holiday and night calls. Similarly, when such overtime attention is requested without being immediately necessary, the members are required to pay the total cost of service. Physician calls for

accident or maternity cases are not subject to control charges regardless of when they occur.

It appears then that the small payments required under either method of remuneration are not so much in the nature of control charges, but rather to remunerate physicians, for holidays and night calls. The rule which requires the patient to pay the total cost of unnecessary night and public holiday calls, however, appears to be the basic technique developed to restrict abuse of service.

The rates of remuneration to physicians are fixed by local negotiation between the representatives of Sick Funds and of the providers of service(1). Apparently these rates are fairly uniform throughout the country. No data are available on the number of physicians in Sick Fund practice, but practically all general practitioners are said to practice under this program. The average annual income from insurance practice in 1949, considering all general practitioners, amounted to approximately 22,000 crowns or about $4,500 Canadian.(2) It should be emphasized that physicians' incomes are derived not only from a fixed annual per capita fee, or on an agreed fee for each service, but also include rather considerable special remuneration payments, as discussed above.

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(1) See pp. 48-50.

(2) See footnote p. 10.

(b) Hospital Benefit Costs

Hospital expenditures, amounting to 22.9 million crowns, represented the second largest item of Sick Fund expenditures in 1949. Hospital costs, as shown in Table V, averaged 9.66 crowns per active member and accounted for 19 per cent of the total health service expenditures. The average cost per patient day for Sick Fund members (adults and children) in 1948 was 3.01 crowns.(1)

An interesting feature of the Danish program is its provision for "impaired risk" coverage of chronic illness. In this regard, it is noteworthy that expenditures for mental and tubercular patients in 1949 accounted for seven per cent of the total expenditures for hospital service benefits for that year.

Table V - AMOUNT AND PERCENTAGE DISTRIBUTION OF HOSPITAL EXPENDITURES AND EXPENDITURES PER ACTIVE ADULT MEMBER, BY TYPE OF HOSPITAL SERVICE, SICK FUNDS, 1949.

Type of Hospital Service	Hospital Expenditures(1)		
	Amount	Per Cent of Total	Per Active Adult Member
	('000 crowns)		
Public	18,465	80.5	7.78
Private	2,771	12.0	1.17
Tuberculosis	1,036	4.5	0.43
Mental	576	2.5	0.25
Travelling	67	0.3	0.03
TOTAL	22,915	100.0	9.66

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Includes expenditures for maternity services in hospital.

(1) As has been mentioned previously, the charges against Sick Funds represent only a fraction of the actual cost from 20-30 crowns per day in 1950.

(c) Pharmaceutical Benefit Costs

Pharmaceutical supplies accounted for the third largest item of Sick Fund expenditure and cost 18.3 million crowns in 1949, or an average of 7.71 crowns per active adult member. This expenditure represented 15.6 per cent of cost of the total health service for that year. The national drug bill, however, would be almost double this amount, since in 1949, Sick Funds paid only three-quarters of the cost of the "vital medicines" and only one-half of the cost of other "specially important" medicines (a permissive benefit until 1951). A breakdown of the 18.3 million crowns expended in 1949 shows that 15.8 million crowns, or 86.3 per cent of the amount, was spent on "specially important" medicines, while the remainder was expended on "vital medicines" (see Appendix IV).

B. SICK BENEFIT SOCIETIES

REVENUES

The total revenue of Sick Benefit Societies in 1949 was 18.5 million crowns, or about 11 per cent of the total revenue of the subsidized Sick Funds for that year. Sick Benefit Societies, which offer persons "with means", benefits comparable to those offered to the active members of the subsidized Sick Funds, receive no subsidies from either the state or local governments and are financed entirely through membership contributions.

TOTAL EXPENDITURES

The total expenditure of the Sick Benefit Societies for 1949 was 17,519,000 crowns, representing an expenditure of 55.44 crowns per active adult member, including administration. These figures compare with a total expenditure of 161.9 million crowns, or an average of 68.25 crowns per active adult member, by the subsidized Sick Funds, which cover approximately 90 per cent of all actively insured persons.

(1) Expenditures by Items

The 1949 expenditures of Sick Benefit Societies are shown in Table VI below. Expenditures, as in the case of the Funds, are largest for medical practitioner and hospital services. It will be noted, however, that expenditures on pharmaceuticals, maternity services and cash maintenance benefits, represented very small payments by the Societies, both in absolute and relative terms. The absence of dental care benefits and the proportionately large sums spent on massage and baths by the Societies, as compared to the Funds, should also be noted. Considering only the amounts spent on health care benefits, i.e., excluding the cost of cash sickness benefits and administration, the Societies spent an average of 49.21 crowns per active adult member as compared to 49.37 crowns by the subsidized Sick Funds, indicating that, while the respective organizations are placing a different emphasis on the type of benefit offered,

they are providing, in monetary terms, total benefits of about the same average value to each member.

Table VI - AMOUNT AND PERCENTAGE DISTRIBUTION OF EXPENDITURES OF SICK BENEFIT SOCIETIES, BY TYPE OF EXPENDITURE, 1949(1)

Type of Expenditure	Amount	Per Cent of Total
	(crowns in million)	
Health benefits		
Medical practitioner services	9.11	51.9
Hospital services	3.94	22.45
Massage and baths	1.48	8.4
Medicine and drugs	0.53	3.0
Maternity	0.48	2.7
Cash benefits	0.53	3.0
Administration	1.43	8.12
TOTAL	17.52(2)	100.0

Source: The Danish Board of Health, 1950.

(1) For 1939-1949 data, see Appendix V.

(2) Does not total exactly, due to rounding of figures.

VI ADMINISTRATION

A notable feature in the administrative development of the Danish health insurance program is the extent to which autonomy of local operation has been retained by the large number of separate insurance associations constituting the system. This is especially interesting in view of the concurrent emergence of greater unified central supervision by the national government. To ensure the effectiveness and continuance of this local autonomy, special bodies have been established representing the interests of the local insurance organizations at the national and regional levels of administration. A discussion of the administrative organization of Sick Funds follows, with particular attention to the methods by which contractual agreements for service are arranged. Sick Benefit Societies are supervised by the same national authority as the Sick Funds and their operations are subject to the approval of this authority.

NATIONAL

The Sick Fund Directorate in the Ministry of Social Affairs is the chief administrative agency of the health insurance program at the national level. Its functions include: approving Sick Funds, supervising operations, determining financial adequacy, paying the amounts due as public susidies, and recommending to the Ministry of

Social Affairs the authorization of the contracts made by the Funds with medical practitioners, dentists, and midwives. In exercising this latter function, the Directorate is empowered to ascertain that the rates of payment fixed in the contract are in suitable proportion to the service to be provided, but this power is rarely used, since agreements of service are generally established by negotiation between the parties concerned.

Two separate bodies, composed of delegates representing the Sick Funds, assist the Directorate at the national level. One of these, the Sick Funds Council, has, as its most important function, the responsibility for making recommendations to the Ministry every three years, concerning the income and capital limits which should be fixed for active membership[1], as well as presenting its opinions on government proposals to amend the Sick Fund legislation. The other body, called the Confederation of Central Unions, is the non-official national organization of Sick Funds which, although without legal responsibility, negotiates with the Directorate all important matters affecting the scheme as a whole. The Confederation also sanctions the agreements of service negotiated by the Funds at the regional level.

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(1) A number of the members of this Council form a committee which acts as the supreme tribunal in disputes arising out of transfers of members from one Sick Fund to another.

Arbitration machinery is provided at the national level for cases involving contractual disputes between Sick Funds and the Medical Association. This machinery consists of a ministerially established Arbitration Council of six elected members (three representing the Sick Funds and three, the medical profession). The Council's decisions are binding on both parties except in cases where one of the parties has not agreed to bring the dispute before the Council. In the latter instance, the cases go before the Minister of Social Affairs who attempts to negotiate a settlement. Referrals to the Arbitration Council on disputes involving the liability of a Fund, with respect to individual physicians are rare, and are settled locally by negotiation between the organizations concerned.

While disputes between the medical profession and Sick Funds are under consideration, physicians must continue to serve Fund members for a period of not longer than three months on the same basis as before the dispute arose.

REGIONAL

At the regional level, Sick Funds are organized into Central Unions, the executives of which are elected by executive committees of the component local Sick Funds. The Central Unions are responsible, with the approval of the national supervisory authorities, for negotiating agreements of service on behalf of the Sick Funds with the local branches

of the Danish Medical Association and with specialists, dentists and midwives. In practice, however, many agreements are negotiated jointly by Central Unions representing a certain region, and the agreements with midwives, dentists,(1) and the nursing and masseuses associations are negotiated for the whole country by the Confederation of Central Unions at the national level. While agreements for service may be negotiated by individual Central Unions with local medical associations, (and sanctioned by the Danish Medical Association), there are only small regional differentials with respect to the rates of remuneration.

LOCAL

Sick Funds, usually only one to a designated area, are largely self-governing units under the program. The administration of each Sick Fund is conducted by a managing committee, which, together with its chairman, is elected directly by the membership. The staff of the Fund, which administers both health service and cash benefits, is appointed by and responsible to the managing committee, the executive authority.

The accounts of the Fund are audited annually by two auditors elected by the membership and annual statements are submitted to the Sick Fund Directorate. In addition,

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(1) Two agreements are negotiated at the national level with respect to dentists, one covering the capital city and another, the remainder of the country.

travelling auditors from the Directorate audit local accounts about every three years, and also guide the Funds in matters of administration.

Membership contributions are usually paid monthly, directly to the local office of the Fund, but in rural areas, contributions are often made on a quarterly basis through collectors employed by the local Funds. It is interesting to note that Sick Funds, with a membership of approximately 90 per cent of all actively insured persons, expended approximately 11.8 per cent of their total costs on administration, as compared to 8.1 per cent in the case of Sick Benefit Societies or, in per capita terms, 7.2 crowns as compared to 4.5 crowns. Thus, with a membership of approximately nine times that of the Societies, the Funds spend about 60 per cent more per capita on administration. It should be emphasized, however, that in 1949 the Funds administered expenditures totalling 161 million crowns as compared to about 17.5 million crowns by Sick Benefit Societies. Moreover, at least part of the difference in per capita expenditures on administration might possibly be explained by the fact that very few Benefit Societies provide any pharmaceutical benefits, and none provide dental benefits, while on the other hand pharmaceutical benefits, the third largest expenditure by the Funds, are paid on a partial-cost basis, involving extensive clerical procedures. In addition, the cost to the Funds of employing collectors in rural areas would also tend to increase their per capita administrative costs.

APPENDICES

APPENDIX I

NUMBER OF HOSPITAL BEDS, AND NUMBER OF BEDS PER 1000 POPULATION, BY TYPE OF BED, DENMARK, 1949

Type of Hospital Bed	No. of Beds		No. of Beds Per 1000 Population
Beds for Patients with Medical-Surgical Diseases at:			
General Hospitals	20,843		
Sick-wards at certain Institutions	2,433		
Private Clinics run by Physicians	264		
TOTAL		23,540	5.56
Beds at Maternity Departments and Clinics run by Physicians		704	0.17
Beds for Epidemic Diseases		2,382	0.56
Beds at Health Resorts		1,200	0.28
Beds at State-regulated Convalescent Homes		1,000	0.24
Beds for Tuberculosis at:			
Sanitoria	1,717		
Tuberculosis Hospitals	1,379		
Seaside Hospitals	381		
Seaside Sanatoria	631		
Convalescent Homes	273		
TOTAL		4,381	1.04
Beds at Hospitals for Epileptics		894	0.21
Beds for Mental Diseases at:			
Medical-Surgical Hospitals	472		
State Mental Hospitals	7,495		
Municipal Mental Hospitals	2,402		
Private Mental Hospitals	162		
TOTAL		10,531	2.49
Beds for Children with Congenital Syphilis		80	0.02
TOTAL		44,712	10.57

Source: Medical Report for the Kingdom of Denmark in 1949, The National Health Service of Denmark, Copenhagen, 1951.

APPENDIX II

ADULT MEMBERSHIP IN SUBSIDIZED SICK FUNDS AND NON-SUBSIDIZED SICK BENEFIT SOCIETIES, DENMARK, 1939 - 1949

('000 persons)

Year	Subsidized Sick Funds			Non-Subsidized Sick Benefit Societies		
	Active Members	Passive Members	Total	Active Members	Passive Members	Total
1939	2,193	310	2,503	144	4	148
1940	2,239	289	2,528	151	3	154
1941	2,285	309	2,594	159	3	162
1942	2,337	265	2,602	170	3	172(1)
1943	2,387	241	2,628	185	2	187
1944	2,386	241	2,627	221	3	223(1)
1945	2,375	260	2,635	242	3	245
1946	2,370	262	2,632	269	3	272
1947	2,344	270	2,614	300	3	303
1948	2,351	273	2,624	314	4	318
1949	2,373	275	2,648	316	4	320

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951

(1) Does not total exactly, due to rounding.

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APPENDIX III

AMOUNT AND PERCENTAGE DISTRIBUTION OF REVENUE OF SUBSIDIZED SICK FUNDS, BY TYPE OF REVENUE, DENMARK, 1939 - 1949

Year	Members' Contributions			State Subsidy	Commune Subsidy	Interest	Control Charges(1)	Other	TOTAL
	Active	Passive	Total						
	Amount ('000 crowns)								
1939	53,732	558	54,290	19,482	2,013	1,355	829	1,694	79,663
1940	55,857	572	56,429	19,831	2,211	1,526	791	1,764	82,553(2)
1941	66,136	748	66,884	21,770	2,404	1,950	934	3,233	97,175
1942	70,069	915	70,984	23,656	2,875	1,815	1,056	6,688	107,073(2)
1943	76,417	736	77,153	25,320	3,335	1,636	1,209	7,310	115,963
1944	82,824	675	83,499	28,766	3,680	1,454	1,383	8,539	127,321
1945	85,910	662	86,572	26,410	3,566	1,360	1,335	7,792	127,035
1946	89,257	708	89,965	28,131	3,683	1,315	1,412	7,402	131,908
1947	107,667	807	108,474	30,594	4,132	1,300	1,566	6,539	152,753(2)
1948	111,884	719	112,603	31,781	3,675	1,618	1,934	6,474	158,085
1949	114,960	709	115,669	34,056	3,960	1,803	2,057	6,629	164,176(2)
	Percentage of Total								
1939	67.5	0.7	68.2	24.5	2.5	1.7	1.0	2.1	100.0
1940	67.7	0.7	68.4	24.0	2.7	1.8	1.0	2.1	100.0
1941	68.0	0.8	68.8	22.4	2.5	2.0	1.0	3.3	100.0
1942	65.4	0.9	66.3	22.1	2.7	1.7	1.0	6.2	100.0
1943	65.9	0.6	66.5	21.8	2.9	1.4	1.1	6.3	100.0
1944	65.1	0.5	65.6	22.6	2.9	1.1	1.1	6.7	100.0
1945	67.6	0.5	68.1	20.8	2.8	1.1	1.1	6.1	100.0
1946	67.7	0.5	68.2	21.3	2.8	1.0	1.1	5.6	100.0
1947	70.5	0.5	71.0	20.0	2.7	0.9	1.0	4.3	100.0
1948	70.8	0.5	71.3	20.1	2.3	1.0	1.2	4.1	100.0
1949	70.0	0.4	70.5	20.7	2.4	1.1	1.3	4.0	100.0

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) See p. 40.

(2) Does not total exactly, due to rounding.

APPENDIX IV

EXPENDITURES OF SUBSIDIZED SICK FUNDS, BY TYPE OF EXPENDITURE, DENMARK, 1939 - 1943

('000 crowns)

Type of Expenditure	1939	1940	1941	1942	1943	(Cont'd next page)
Health Benefits						
Medical practitioner						
General	19,955	20,253	23,463	24,585	26,779	
Specialist	3,461	3,435	4,099	4,523	5,012	
Hospital(1)						
Public	10,613	10,741	12,563	14,442	15,685	
Mental	543	540	506	470	489	
Tuberculosis	812	775	779	863	1,085	
Private	1,386	1,214	1,379	1,550	1,780	
Travelling	34	33	33	49	51	
Convalescent homes	454	401	513	582	580	
Maternity(2)	3,370	3,846	4,445	5,273	5,912	
Pharmaceutical						
Vital medicines	693	803	954	1,228	1,365	
Other medicines	8,828	8,997	8,261	9,559	10,966	
Dental care	3,547	4,101	4,615	5,507	6,194	
Appliances, spectacles	1,120	1,008	1,279	1,478	1,650	
Home nursing	1,218	1,298	1,406	1,499	1,574	
Message, baths	667	637	721	862	1,031	
Other (including funeral aid)(3)	1,361	1,311	9,655	14,680	14,747	
TOTAL	58,061(5)	59,396(5)	74,671(5)	87,152(5)	94,900(5)	
Cash Sickness Benefits(4)	9,716	9,099	8,661	8,808	9,003	
Administration	8,546	9,470	12,043	12,029	12,589	
GRAND TOTAL	76,323	77,964	95,375	107,989	116,492	

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Includes expenditures for confinements in nursing homes or hospitals.
(2) Includes daily allowances paid in maternity cases.
(3) Funeral aid amounted to 5 million crowns in 1948; not included for 1939 and 1940.
(4) For additional cash benefits, see footnote 2.
(5) Does not total exactly.

EXPENDITURES OF SUBSIDIZED SICK FUNDS, BY TYPE OF EXPENDITURE, DENMARK, 1944 - 1949

('000 crowns)

Type of Expenditure	1944	1945	1946	1947	1948	1949
Health Benefits						
Medical practitioner						
General	28,327	28,714	32,156	38,460	39,584	42,513
Specialist	5,563	5,791	6,545	7,845	8,373	9,697
Hospital(1)						
Public	16,051	15,652	15,831	15,995	17,035	18,465
Mental	474	464	532	529	483	575
Tuberculosis	1,152	1,135	1,185	1,140	1,068	1,036
Private	1,840	1,714	1,843	1,949	1,996	2,771
Travelling	56	48	34	63	59	67
Convalescent homes	571	585	690	727	1,012	1,228
Maternity(2)	6,693	7,034	7,593	7,393	7,113	7,035
Pharmaceutical						
Vital medicines	1,573	1,601	1,630	1,845	2,132	2,472
Other medicines	12,744	12,599	13,366	13,370	14,703	15,840
Dental care	6,233	6,072	6,154	7,177	7,717	8,258
Appliances, spectacles	1,644	1,549	1,887	2,227	2,607	2,924
Home nursing	1,738	1,925	2,053	2,486	2,609	2,562
Massage, baths	1,007	1,134	1,311	1,293	1,566	1,714
Other (including funeral aid)(3)	15,176	15,113	14,943	14,490	15,295	15,099
TOTAL	100,931(5)	101,089(5)	107,753(5)	117,938(5)	123,352(5)	132,256(5)
Cash Sickness Benefits(4)	9,722	9,061	10,233	9,944	9,609	10,587
Administration	13,280	14,067	15,949	16,598	17,649	19,129
GRAND TOTAL	123,933	124,217	133,935	144,480	150,610	161,972

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Includes expenditures for confinements in nursing homes or hospitals.
(2) Includes daily allowances paid in maternity cases (1.5 million crowns in 1948).
(3) 310 thousand crowns for "Hald", a private hospital for chronic patients, included in 1949. Funeral aid amounted to 5 million crowns in 1948; not included for 1939 and 1940.
(4) See footnote (2) above.
(5) Does not total exactly.

APPENDIX V

EXPENDITURES OF NON-SUBSIDIZED SICK BENEFIT SOCIETIES, BY TYPE OF EXPENDITURE, DENMARK, 1939 - 1949

('000 crowns)

Year	Type of Expenditure								TOTAL
	Medical	Hospital	Maternity	Medicines, Drugs	Massage, Baths	Cash Benefits	Administration	Other	
1939	2,459	1,132	203	184	410	198	378	7	4,971
1940	2,490	1,157	211	120	377	220	417	13	5,005
1941	3,081	1,349	210	125	439	185	494	14	5,898(1)
1942	3,371	1,580	290	190	523	185	525	9	6,673
1943	3,996	1,878	344	240	602	207	562	13	7,842
1944	4,972	2,283	393	301	740	261	678	8	9,636
1945	5,527	2,667	455	346	771	298	781	16	10,861
1946	6,694	2,889	551	387	888	340	945	13	12,707
1947	7,854	3,340	559	420	952	372	1,243	-	14,740
1948	8,409	3,763	532	494	1,093	413	1,394	13	16,098(1)
1949	9,112	3,941	480	534	1,486	533	1,433	-	17,519

Source: Report of the Director of Sick Fund Activities, Year 1949, Copenhagen, 1951.

(1) Does not total exactly, due to rounding.

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